

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the **Healthiest State** in the Nation

April 29, 2015

Dear Parents:

It has come to our attention that a person at your school is currently being evaluated for the suspicion of Tuberculosis (TB). Tuberculosis is caused by a germ that is spread through the air, therefore we strongly recommend those students, teachers, and other school staff with whom this student had prolonged close contact, be tested for TB. The TB blood test shows if TB germs have infected a person. Your child has been identified as someone who has been in close contact with the person who has suspected active TB. The Florida Department of Health in Pinellas County (DOH-Pinellas) will perform the blood test at no charge at the school on **Tuesday May 5**, between the hours of **7:00 am and 12:30 pm**. If your child will be tested at the school clinic; it is highly recommended he/she eat breakfast and drink plenty of fluids the morning they will be tested.

The TB blood test may be done by your own physician or by DOH-Pinellas. If you choose to have your son/daughter tested by your physician, we will need a written statement of the type of TB test and the results. We will also need to know the physician's name and phone number.

Your permission is needed in order for your son/daughter to have the TB test done at the school.

PLEASE FILL OUT AND SIGN THE PERMISSION SLIP BELOW, AND RETURN IT TO THE SCHOOL CLINIC AS SOON AS POSSIBLE.

To be tested at the Florida Department of Health in Pinellas County, please call (727) 824-6953 for an appointment. If you have any questions, please feel free to call and speak to a TB Nurse at **(727) 824-6953**.

PERMISSION SLIP

Student Name _____ Date of Birth _____
Last First Middle (please print)

Address _____

Grade _____ Teacher _____

Has your child ever had a TB test? Yes No If yes, Date _____

Name of clinic/physician _____ Telephone # _____

I hereby grant permission to the Florida Department of Health in Pinellas County to perform a TB blood test on the above named child.

Parent Signature _____ Date _____

Florida Department of Health

in Pinellas County
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www.FloridaHealth.gov

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